PAIN CLINIC
OF LAKE SUPERIOR
1420 London Road - Suite 100 - Duluth, MN 55805
Phone 218.728.8548 - Fax 218.728.8554
LakeSuperiorPain.com

PATIENT HEALTH HISTORY

PAIN PATIENTS

REFERRING PHYSICIAN: _____

What **medications** and/or supplements do you currently take:

Advanced Directives ❑ Yes ❑ No Location _____

NAME and DOSAGE:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have any **allergies** (or sensitivities)? ❑ Yes ❑ No

_____

Do you smoke? ❑ No ❑ Yes Yes, # of years and # of packs per day _____/_____/ day

Do you drink alcohol? ❑ No ❑ Yes Yes, frequency _____

Are you currently pregnant? ❑ No ❑ Yes

Emergency Contact: _____

Phone Number: _____

MEDICAL HISTORY:

Do you have or have you had any of the following medical problems? Please give details and list the date of the problem on the spaces below.

❑ No	❑ Yes	**Diabetes**	❑ No	❑ Yes	**Unusual Bleeding Tendencies**
❑ No	❑ Yes	**High Blood Pressure**	❑ No	❑ Yes	**Cancer**
❑ No	❑ Yes	**Heart Disease**	❑ No	❑ Yes	**Neurologic Disease**
❑ No	❑ Yes	**Lung Disease**	❑ No	❑ Yes	**Mental Illness/Depression**
❑ No	❑ Yes	**Kidney Disease**	❑ No	❑ Yes	**Alcohol/Chemical Dependency**
❑ No	❑ Yes	**Gastrointestinal Disease**	❑ No	❑ Yes	**Exposure to HIV/Hepatitis**
❑ No	❑ Yes	**Liver Disease**	❑ No	❑ Yes	**Previous Serious Injury/Illness**
❑ No	❑ Yes	**Arthritis**	❑ No	❑ Yes	**Problems with Anesthesia**
			❑ No	❑ Yes	**MRSA/VRE/C-DIFF**

_____
_____
_____

Please list any previous **surgical procedures** and the date they occurred:

_____
_____

Have you ever had an x-ray or MRI pertaining to your pain? ❑ No ❑ Yes

If yes, where and when? _____

Family history of: ☐ Arthritis ☐ Fibromyalgia ☐ Depression ☐ Anxiety

Review of Systems

CONSTITUTIONAL: ☐ Poor Energy ☐ Fever ☐ Fatigue ☐ Change in Appetite
EARS/NOSE/MOUTH/THROAT: ☐ Hoarse Voice ☐ Ringing in Ears ☐ Difficulty Swallowing ☐ Hearing Impaired
HEART/CARDIOVASCULAR: ☐ High Blood Pressure ☐ Previous Heart Attack ☐ Abnormal Heart Rhythm ☐ Angina/Chest Pain ☐ Passing Out/Fainting ☐ Blood Clots/Phlebitis (DVT)
HEMATOLOGIC/LYMPHATIC: ☐ Increased Bleeding ☐ Increased Bruising ☐ Limb Swelling
LUNGS /RESPIRATORY: ☐ Shortness of Breath ☐ Cold, Cough or Bronchitis now ☐ Wheezing
ALLERGY/IMMUNOLOGY ☐ Adhesive Tape ☐ Latex ☐ Betadine
GASTROINTESTINAL STOMACH/ INTESTINES/LIVER: ☐ Abdominal Pain ☐ Reflux/Heartburn ☐ Constipation ☐ Diarrhea ☐ Incontinence Stool ☐ Nausea
GENITOURINARY: ☐ Pain with Urination ☐ Incontinence of Urine ☐ Increased Frequency of Urination ☐ Difficulty with Sexual Functioning
SKIN: ☐ Color Changes
BONES / JOINTS / MUSCLES: ☐ Joint Pain ☐ Joint Swelling ☐ Weakness ☐ Back/Neck Pain ☐ Muscle Aches
ENDOCRINE: ☐ Weight Gain ☐ Weight Loss ☐ Heat or Cold Intolerance ☐ Night Sweats ☐ Increased Thirst
NEUROLOGIC: ☐ Memory Loss ☐ Problems with Nighttime Sleep ☐ Tremors ☐ Snoring ☐ Dizziness ☐ Poor Balance ☐ Headache ☐ Falling/Walking Difficulty ☐ Numbness/Tingling
PSYCHIATRIC: ☐ Depressed ☐ Anxious ☐ Mood Changes ☐ Hallucinations

Treatment	Tried? (Yes/No)	Helpful? (Yes/No)	Other info
Chiropractor	☐ Yes ☐ No	☐ Yes ☐ No	
Braces	☐ Yes ☐ No	☐ Yes ☐ No	
Injections	☐ Yes ☐ No	☐ Yes ☐ No	
Physical Therapy	☐ Yes ☐ No	☐ Yes ☐ No	
Acupuncture	☐ Yes ☐ No	☐ Yes ☐ No	
Medications	☐ Yes ☐ No	☐ Yes ☐ No	
Tens Unit	☐ Yes ☐ No	☐ Yes ☐ No	
Surgery	☐ Yes ☐ No	☐ Yes ☐ No	

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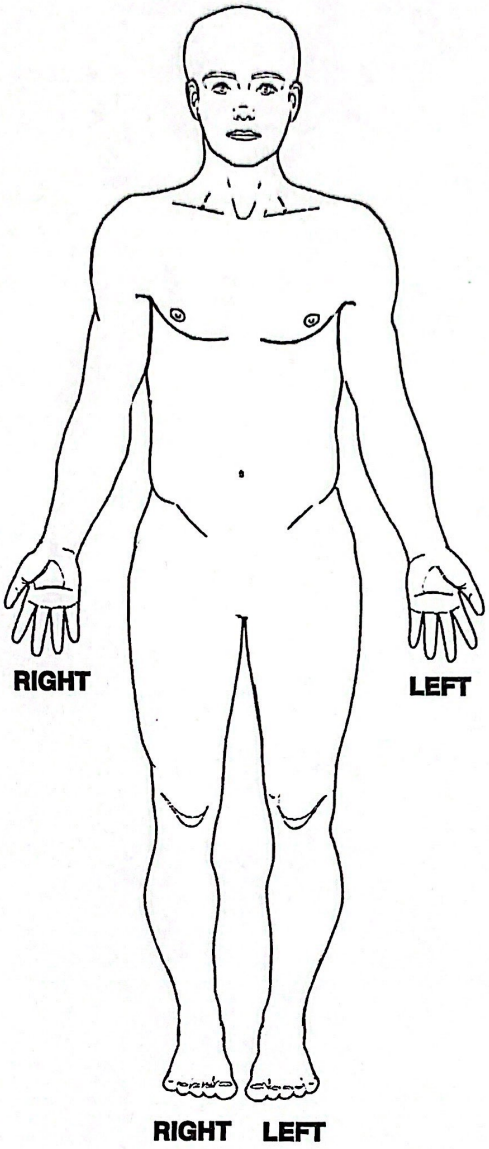
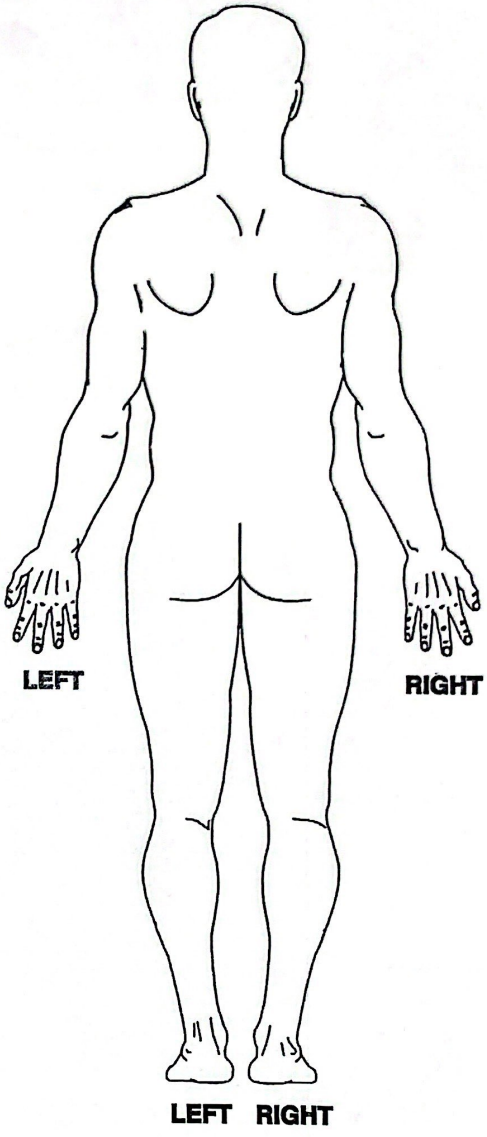
Pain Intensity Scale





Are you on blood thinners or steroids? Yes ☐ No ☐

Numbness Yes ☐ No ☐ Pain increases with: _____

Tingling Yes ☐ No ☐ Pain decreases with: _____

Least Pain	0	1	2	3	4	5	6	7	8	9	10
Average Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10
	No Pain			Discomforting			Distressing				Excruciating